

The Evanescence of Living Wills

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I. INTRODUCTION

Ordinary wills dispose of property after death. Living wills direct medical treatment at the end of life, before death has come but when competence is lost. The analogy explicit in naming living wills after ordinary wills emphasizes that both speak after their maker no longer can express voice, about a very important part of life's closure.

Yet the pun is misleading. Despite their similarity of nomenclature, living wills and ordinary wills are very different types of directives. The differences can be summed up by saying that ordinary wills are performative, whereas living wills are not. The act of making an ordinary will effects powerful changes with respect to the distribution of property. By contrast, the current legal treatment of living wills assures only relatively limited and fragile changes in the medical treatment of an individual. In many jurisdictions, an individual can "turn down" medical care, even though they have become incompetent, without a living will. But an individual cannot distribute their property after death without a real will. On the other side, real wills are effective until they are formally revoked or replaced; living wills may lose force with the simple expression that an individual's desires have changed.

Moreover, the law responds very differently to changes of desires with respect to the disposition of property after death and of one's person after competence has been lost. The problems posed by expressed changes of desire are complex, especially when a person's competence is in doubt at the time when the change is expressed. Consider a person who has stoutly maintained over the years that she never wants to be dependent or a burden, as she might be if respirator-dependent, but who during the downhill course of amyotrophic lateral sclerosis apparently responds affirmatively to questions about use of a respirator. Questions of competence, understanding, and the

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reliability of communication are obvious in this example. So also is the policy issue of whether to err on the side of life. Moreover, there are arguments to be made in favor of following either the current or the earlier preferences. On the one hand, current preferences may be better informed than earlier, inexperienced preferences; life with a disability such as incontinence or immobility may seem better—or worse—than one had thought it would be in the abstract. On the other hand, immediate preferences may not reflect longer term desires, autonomous choice, or longstanding conceptions of how life is to be lived. Just as Ulysses firmly determined in advance to be restrained from the Sirens, yet begged to be released when he heard them, intensely expressed present desires may not realize one's longer view of the shape of one's life or one's death.¹

This article will first compare the performative structure of ordinary wills with the weaker force of living wills. It will then examine the policies behind these differences: for ordinary wills, predominantly the need for certainty in the distribution of property; for living wills, the protection of life. The law of ordinary wills reflects liberal political theory about the rights of individuals to do as they wish with their property, tempered by the social need for certainty about control of property; the law of living wills limits autonomous choice by the protection of life. It will be argued that it is in some respects wise to structure living wills as non-performative, but that living wills should not be as limited in scope as they are. Finally, the analysis will be applied to the hardest situation involving living wills, that of apparent change of desires by a person whose competence becomes questionable.

II. ORDINARY WILLS

Making an ordinary will is an act of great legal significance. From the moment of its making, an ordinary will orchestrates the disposition of an individual's property at death. The impact of an ordinary will is usually ongoing, despite changed circumstances or expressed desires. There are a number of ways in which the structure of the law of ordinary wills manifests their continuing performative character.

First, an individual's desires with respect to the distribution of property have no legal status without a valid ordinary will. No matter how frequently, how loudly, or how convincingly they are expressed, personal desires are irrelevant to property distributions. An individ-

¹ For a discussion of the problem of changed preferences and rational choice theory, see J. ELSTER, *ULYSSES AND THE SIRENS* (1984).

ual who dies without an ordinary will dies intestate, and the state statute governing intestate succession takes over.² To be sure, intestate succession statutes are constructed to reflect both public policy considerations and generalizations about how people might want their property to be distributed: to spouses, children, parents, and other less closely related family members.³ These generalizations, however, are gross at best and may well be inaccurate in a particular case. Even if the evidence is overwhelming that distributing the decedent's assets according to the statute does not mirror someone's wishes, it will, nevertheless, be applied unless the formal mechanism of a will has been invoked. Someone can say daily that she never wants a penny of her property to go to her ungrateful daughter; without a will, these comments are legally insignificant.

A second feature of the performative structure of ordinary wills is their continued life. Valid wills remain in effect until they are formally revoked, by a new will or by destruction, or until divorce.⁴ Expressions of desires to change or undo a will are legally unavailing until the will is defaced or replaced by its maker according to statutory form.⁵ Someone who has announced to the world that he is on his way to change his will, but is killed en route, dies with his old will unaltered.

There is a doctrine of mistake in the traditional law of wills, but it does not center on whether the will adequately reflects the testator's desires. An instrument is invalid if at the time of execution, its maker does not know it is a will or does not know its contents.⁶ If the testator knows the will's contents, however, but omits an important provision or misunderstands the legal effect of what the will provides, the court will not reform the will despite what the testator's desires might have been.⁷ Courts also refuse to reform wills despite mistakes about important extrinsic facts, including such highly relevant factors as paternity.⁸ Nor is it relevant that the testator's desires changed between the time he made the will and the time of his

² See, e.g., UTAH CODE ANN. § 75-2-101 (1978); UNIFORM PROBATE CODE § 2-101 (West 1982).

³ See, e.g., UTAH CODE ANN. § 75-2-102 & comment (Supp. 1987). The Comment to the Uniform Probate Code § 2-102 asserts that allocating at least a one-half share to the decedent's spouse better reflects the desires of married persons than most earlier statutes on the descent of property. UNIFORM PROBATE CODE § 2-102 comment.

⁴ UNIFORM PROBATE CODE §§ 2-507, 2-508 (West 1982).

⁵ *Id.* at § 2-508. ("No change of circumstances other than as described in this section revokes a will."). T. ATKINSON, LAW OF WILLS, § 84, at 22 (2d ed. 1953).

⁶ 1 PAGE ON WILLS §§ 13.3, 13.4 (3d ed. 1960).

⁷ ATKINSON, *supra* note 5, § 60, at 281; PAGE ON WILLS, *supra* note 6, at 13.7.

⁸ PAGE ON WILLS, *supra* note 6, at 13.7.

death, unless a will has been formally revoked. Traditional commentators attribute this to the importance of formality in the law of wills.⁹

To be sure, there may be challenges to whether the will reflects the autonomous choice of its maker. For example, questions may be raised about whether undue pressure was placed on the maker of the will, or whether the maker of the will was of sound mind. But, like the doctrine of mistake, these will be treated as challenges to the original validity of the will, not as concerns about whether the will reflects what its maker really wanted. Evidence relevant to such challenges will include the testator's capacity and pressures upon him,¹⁰ but not whether the will evidences his preferences.

Challenges may also be raised to the meaning of wills. If, for example, a will contains an apparent misdescription, an issue of interpretation may be raised. But it will be treated conventionally only as a matter of understanding the testator's intent as expressed in the document, not as a matter of unearthing the testator's actual desires.¹¹ Only in cases of outright ambiguity will evidence of the testator's intent traditionally be admitted.¹²

There are, finally, public policy limits on what a testator may do by means of a will. The rule against perpetuities prevents property from being left in limbo indefinitely. The decedent's spouse may take an elective share, clearly an enforced transfer.¹³ Many state statutes now prohibit homicidal devisees from profiting under a victim's will.¹⁴ Despite these limits, however, having a valid will makes nearly all the difference in what happens to one's property after death.

III. LIVING WILLS

Unlike ordinary wills, living wills are not performative. Their making does not change all; indeed, it may change very little. The individual's expressed desires may have legal effect without the making

⁹ PAGE ON WILLS, *supra* note 6, at 13.12 (Supp. 1986).

¹⁰ ATKINSON, *supra* note 5, § 100, at 531.

¹¹ See, e.g., UNIFORM PROBATE CODE § 2-603 (West 1982); UTAH CODE ANN. § 75-2-603 (1978) ("The intention of a testator as expressed in his will controls the legal effect of his dispositions. The rules of construction expressed in the succeeding sections . . . apply unless a contrary intention is indicated by the will."); PAGE ON WILLS, *supra* note 6, at 13.9.

¹² ATKINSON, *supra* note 5, § 60, at 281.

¹³ UNIFORM PROBATE CODE § 2-201 (West 1982).

¹⁴ *Id.* at § 2-803; DWORKIN, LAW'S EMPIRE 15-20 (1986). For example, in *Riggs v. Palmer*, 115 N.Y. 506, 22 N.E. 188 (1889), the court would not allow a murdering nephew to take under his grandfather's will. The court's disallowance has become a classic in jurisprudential discussions of the relationship between morality and law.

of a living will. Similarly, expressed desires other than those embodied in a living will may have continued effect despite the will's existence. And living wills can be undone by evidence that they no longer reflect desires, despite the lack of formal revocation.

A. *The Limited Nature of Living Wills*

By early 1987, some thirty-eight states and the District of Columbia had living will legislation.¹⁵ The advent of living will legislation has been regarded as a major gain by those supporting values of individual choice and "death with dignity." Yet most living will statutes add little beyond clarification to the legal rights of patients. Despite their grand title, living wills are very limited in scope.¹⁶ Two limits are most important to what they can accomplish. First, in most states they are only effective to refuse extraordinary, life-prolonging care. Second, they are effective to refuse care only after a patient has become terminally ill—or, in some states, when death is very near; they are not advance directives through which treatment can be refused more generally.

1. *Types of Care That Can Be Withheld Under a Living Will.* The types of care that may be refused by living wills vary from state to state. By far the predominant approach is a basic refusal of interventions without prospect of real improvement or cure. Widely circulated living will forms typically describe the treatment to be refused with general adjectives such as "life-sustaining" or "life-prolonging." For example, the living will form recommended by the recent Presidential commission on ethical problems in health care directs the withholding of "life-sustaining procedures," and in their place natural death with "only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort care" or to alleviate pain.¹⁷ The 1985 Uniform Rights of the Terminally Ill Act, now adopted in six states, suggests a simple form refusing treatment that "only prolongs the process of dying and is not necessary to . . . comfort or to alleviate pain."¹⁸ The definition of life-sustaining treatment suggested in the Uniform Act uses the

¹⁵ A MATTER OF CHOICE: PLANNING AHEAD FOR HEALTH CARE DECISIONS 41 (American Assoc. of Retired Persons 1987).

¹⁶ For a criticism of living wills which emphasizes their limits as a method of dialogue between patients and physicians, see S. Johnson, *Sequential Domination, Autonomy and Living Wills*, 9 W. NEW ENGL. L. REV. 113 (1987).

¹⁷ President's Comm'n for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, *Deciding to Forgo Life Sustaining Treatment* 314-15 (1982).

¹⁸ UNIFORM RIGHTS OF THE TERMINALLY ILL ACT § 2(b), 9b U.L.A. 614 (1987). The six adopting states are Alaska, Iowa, Maine, Missouri, Montana, and Oklahoma.

same language: "any medical procedure or intervention that, when administered to a qualified patient, will serve only to prolong the process of dying."¹⁹ Many other state statutes suggest similar forms.²⁰

These basic forms apparently leave to medical judgment the distinction among life-prolonging care, comfort, and cure. Artificial respiration and circulation, and cardiopulmonary resuscitation, are typically deemed to prolong dying and thus to be withheld under the general language of a living will.²¹

On the other side, painkillers are generally regarded as part of comfort care and thus administered, although debate still surrounds the use of dosages that risk shortening life. One state, Vermont, suggests a living will form in which the patient requests "that medication be mercifully administered to me to alleviate suffering even though this may shorten my remaining life."²² Other state statutes contain no explicit provisions about the risks of painkillers.

Dialysis, transfusions, palliative chemotherapy, and transplant surgery are forms of care that are highly interventionist but may enable life to be continued for relatively extended periods. Despite the fact that patients might differ about the desirability of undergoing these procedures and about the quality of life they produce, these are not viewed as merely drawing out the dying process, and therefore, would not be encompassed under a general living will. The commentary to the Uniform Act, for example, describes both diabetes treatable with insulin and kidney disease managed with dialysis as "reversible" conditions. This is surely a pickwickian characterization at best because neither condition is curable, and the quality of life for individual patients may vary tremendously. There are exceptions to these judgments: Wisconsin's living will statute stipulates that artificial respiration and circulation, blood transfusions, and dialysis should be regarded as "life-sustaining processes," but draws the line at artificial nutrition and hydration.²³

Tennessee's statute contains perhaps the most thorough effort to

¹⁹ *Id.* at § 1(4), at 611.

²⁰ See, e.g., ALA. CODE § 22-8A-4 (1975); CAL. HEALTH & SAFETY CODE § 7188 (Deering Supp. 1987); D.C. CODE ANN. § 6-2422(c) (Supp. 1987); LA. REV. STAT. ANN. § 40:1299.58.3(C) (West Supp. 1987); MISS. CODE ANN. § 41-41-107 (West Supp. 1986); MONT. CODE ANN. § 50-9-103 (1986); NEV. REV. STAT. § 449.610 (1986); OR. REV. STAT. § 97.055(1) (Supp. 1983); TEX. REV. CIV. STAT. ANN. ch. 71, art. 4590h, § 3(d) (Vernon 1981); VA. CODE ANN. § 54-325.8:4 (Supp. 1987); WASH. REV. CODE ANN. § 70.122.030(1) (Supp. 1987).

²¹ See, e.g., S. Youngner, *Do-Not-Resuscitate Orders: No Longer Secret, But Still a Problem*, 17 HASTINGS CENTER REP. 24 (Feb. 1987).

²² VT. STAT. ANN. tit. 18 § 5253 (Supp. 1986).

²³ WIS. STAT. ANN. § 154.01(5) (West Supp. 1986).

distinguish among forms of care. Tennessee expansively describes the medical care that may be refused in a living will as including "surgery, drugs, transfusions, mechanical ventilation, dialysis, cardiopulmonary resuscitation, artificial or forced feeding, radiation therapy, or any other medical act designed for diagnosis, assessment, or treatment to sustain, restore, or supplant vital body function." The statute excludes, however, "the withholding of simple nourishment or fluids so as to condone death by starvation or dehydration."²⁴ Tennessee also suggests a non-exclusive list of what might be regarded as comfort care, which cannot be refused by general living will language: sedatives and painkillers, nonartificial oral feeding, suction, hydration, and hygienic care.²⁵

Administration of antibiotics, nutrition, and hydration have been the most problematic areas to date. In some respects, these resemble ordinary care or simple human kindness; food and water in particular are traditional symbolic forms of ministration to the sick. Yet artificial feeding and hydration are invasive and uncomfortable, involving either insertion of a tube through the nose into the stomach or surgical entry into the intestine. More disturbingly, withholding sustenance may be the only ready method of ending the process of dying for patients hovering in conditions such as irreversible coma. Karen Ann Quinlan, for example, in her persistent vegetative state, was weaned from the respirator but was entirely dependent on artificial feeding for nearly ten years.²⁶ Both the courts²⁷ and the medical profession have recently become more willing to consider the appropriateness of withholding sustenance from an otherwise hopeless patient; the most recent American Medical Association ethical opinion on the subject, for example, says that "[l]ife prolonging treatment includes medication and artificially or technologically supplied respiration, nutrition or hydration. In treating a terminally ill or irreversibly comatose patient, the physician should determine whether the benefits of treatment outweigh its burdens. At all times, the dignity of the patient should be maintained."²⁸

The living will statutes of nearly half of the states specifically exclude artificial nutrition and hydration from the category of life-sus-

²⁴ TENN. CODE ANN. § 32-11-103(5) (Supp. 1986).

²⁵ *Id.* at § 32-11-103(6).

²⁶ For a discussion of the issues of nutrition and hydration, see J. LYNN, *BY NO EXTRAORDINARY MEANS: THE CHOICE TO FORGO LIFE-SUSTAINING FOOD AND WATER* (1986).

²⁷ See, e.g., *In re Jobes*, 529 A.2d 434 (N.J. 1987).

²⁸ AMA Council on Ethical and Judicial Affairs, *Withholding or Withdrawing Life Prolonging Medical Treatment* (Mar. 15, 1986).

taining treatment refused by a living will.²⁹ In some of these states, the statutory prohibition is absolute.³⁰ In others, the maker of a living will may add other treatment refusal directives, but nothing is said particularly about the addition of directives concerning food or water.³¹ Only one state, Utah, specifies that the maker of a living will may refuse nutrition and hydration or antibiotics by explicit direction.³²

In states without an explicit exclusion of nutrition and hydration from the living will form, it remains unclear whether a general refusal of life-sustaining treatment in a directive will be taken to encompass nutrition and hydration. No cases have addressed this specific issue. Some states, however, have faced the question of whether the right to refuse treatment outside the living will context extends to nutrition and hydration, and have held that it does.³³ Lower court decisions in New York, however, have distinguished artificial respiration from tube feedings and refused to extend the right to refuse treatment on behalf of an incompetent to nutrition and hydration.³⁴ While the New York legislature has the matter under study, it has not yet adopted a general living will statute; and the court's refusal was based in part on reluctance to take judicial action on what it viewed as a policy issue demanding legislative resolution.³⁵

Many of the state statutes that suggest general refusal language also invite clarification by the maker of a non-treatment directive. Makers of living wills may incorporate additional, specific types of treatment they wish to refuse. This opportunity has the advantages

²⁹ See, e.g., ARIZ. REV. STAT. ANN. § 32-3201(4) (Supp. 1986); COLO. REV. STAT. ANN. § 15-18-104(7) (Supp. 1986); CONN. GEN. STAT. § 19a-570 (1987); FLA. STAT. ANN. § 765.03(3) (West 1986); GA. CODE ANN. § 31-32-2(5)(A) (Supp. 1987); HAW. REV. STAT. § 327D-2 (1986); IDAHO CODE § 39-4503(4) (1977); ILL. ANN. STAT. ch. 110½, para. 702(2)(c) (Smith-Hurd 1987); IND. CODE ANN. § 16-8-11-4 (West Supp. 1987); ME. REV. STAT. ANN. tit. 22, § 2921 (Supp. 1987); MD. HEALTH-GENERAL CODE ANN. § 5-602(c)(1) (Supp. 1986); N.H. REV. STAT. ANN. § 137-H:2 (Supp. 1986); OKLA. STAT. ANN. tit. 63, § 3102(4) (West Supp. 1987); OR. REV. STAT. § 97.050(3) (1983); S.C. CODE ANN. § 44-77-20.6 (Law Co-op. Supp. 1986); UTAH CODE ANN. § 75-2-1103(6)(b) (Supp. 1987); WIS. STAT. ANN. § 154.01(5) (West 1986).

³⁰ COLO. REV. STAT. ANN. § 15-18-104(7) (Supp. 1986); IDAHO CODE § 39-4503(3) (1977); MD. HEALTH-GENERAL CODE ANN. §§ 5-602(c)(1), 5-605 (Supp. 1986); OR. REV. STAT. § 97.050(3) (1983); WIS. STAT. ANN. § 154.01(5)(b) (West 1986).

³¹ ARIZ. REV. STAT. ANN. § 36-3202(c) (Supp. 1986); FLA. STAT. ANN. § 765.03(3) (West 1986); GA. CODE ANN. § 31-32-3(b) (Supp. 1987); HAW. REV. STAT. § 327D-2 (1986); ILL. STAT. ANN. ch. 110½, para. 703(3)(c) (Smith-Hurd 1987); IND. CODE ANN. § 16-8-11-12(b) (West Supp. 1987).

³² UTAH CODE ANN. § 75-2-1104(4) (Supp. 1987).

³³ *Brophy v. New England Sinai Hosp., Inc.*, 398 Mass. 417, 497 N.E.2d 626 (1986); *In re Jones*, 529 A.2d 434 (N.J. 1987); *Corbett v. D'Alessandro*, 487 So. 2d 368 (Fla. App. 1986).

³⁴ *Delio v. Westchester County Med. Center*, 510 N.Y.S.2d 415 (Sup. Ct. 1986).

³⁵ *Id.* at 419.

of clarity and flexibility. It has the disadvantage, however, that the maker of a living will may be unable to anticipate all the forms of treatment he or she wishes to refuse. Medical technology is changing so rapidly that new forms of treatment may become available between the making and the effective date of a living will. Moreover, individuals making a living will may not be aware of invasive forms of treatment. Given these difficulties of anticipation, it is especially important that a living will, by omitting a specific form of treatment, is not taken to represent a deliberate choice against refusing it. Many state statutes take the precaution of providing that patients without living wills are not presumed to desire anything about accepting or refusing treatment.³⁶ Others provide that living wills are to be regarded as supplementary to other desires of the patient.³⁷ No state, however, says specifically that failure to add on other excluded forms of care is not to be taken as a deliberate omission.

2. *The Limitation to Terminal Illness.* A second major limit of living will statutes is that they generally stipulate that the directive only becomes operative after its maker has become terminally ill. Only New Mexico extends non-treatment directives beyond the terminally ill, and the extension only applies to the irreversibly comatose.³⁸

State statutory definitions agree that an illness is not terminal unless it will result in death despite available medical care. Where statutory definitions diverge on the importance of the manner of death. Some state definitions insist that death be imminent.³⁹ Connecticut

³⁶ CONN. GEN. STAT. § 19a-572 (1987); IND. CODE ANN. § 16-8-11-19 (West Supp. 1987); MD. HEALTH-GENERAL CODE ANN. § 5-610(2) (Supp. 1986); MONT. CODE ANN. § 50-9-205(4) (1986); N.H. REV. STAT. ANN. § 137-H:12 (Supp. 1986); S.C. CODE ANN. § 44-77-140 (Law Co-op. Supp. 1986); TENN. CODE ANN. § 32-11-110(e) (Supp. 1987); UTAH CODE ANN. § 75-2-1117(5) (Supp. 1987); WIS. STAT. ANN. § 154.11(5) (West 1986).

³⁷ See, e.g., ALA. CODE § 22-8a-3(6) (1975); CAL. HEALTH & SAFETY CODE § 7193 (Deering Supp. 1987); D.C. CODE ANN. § 6-2429(a) (Supp. 1987); FLA. STAT. ANN. §§ 765.07(3), 765.15 (West 1986); GA. CODE ANN. § 31-32-11(a) (1985); HAW. REV. STAT. § 327D-22 (1986); IND. CODE ANN. § 16-8-11-18(e) (West Supp. 1987); LA. REV. STAT. ANN. § 40:1299, 58.1 (West Supp. 1987); MD. HEALTH-GENERAL CODE ANN. § 5-610(1) (Supp. 1986); MONT. CODE ANN. § 50-9-205(5) (1986); NEV. REV. STAT. § 449.680 (1986); N.H. REV. STAT. ANN. § 137H:16 (Supp. 1986); N.M. STAT. ANN. § 24-7-9 (1978); OR. REV. STAT. § 97.085 (1983); TENN. CODE ANN. § 32-11-110(d) (Supp. 1986); TEX. REV. CIV. STAT. ch. 71, art. 4590h, § 11 (Vernon Supp. 1987); UTAH CODE ANN. § 75-2-1117(4) (Supp. 1987); VA. CODE ANN. § 54-325.8:12 (Supp. 1987); W. VA. CODE § 16-30-9(a) (1985); WIS. STAT. ANN. § 154.11(4) (West 1986).

³⁸ N.M. STAT. ANN. § 24-7-3.A (1978).

³⁹ E.g., ALA. CODE § 22-8A-3(6) (1975) ("patient whose death is imminent or whose condition is hopeless unless he or she is artificially supported"); MD. HEALTH-GENERAL CODE ANN. § 5-601(g) (Supp. 1986); FLA. STAT. ANN. § 765.03(6) (West 1986); S.C. CODE ANN. § 44-77-20(d) (Law Co-op. Supp. 1986); VA. CODE ANN. § 54-325.8:2 (Supp. 1987). For a criticism of Virginia's

insists that a patient be in the "final stage of an incurable or irreversible medical condition which, in the opinion of the attending physician, will result in death,"⁴⁰ a requirement that surely excludes, for example, patients with midstage Alzheimer's disease. Maryland says that a patient must suffer from an incurable condition which "makes death imminent" and further describes life-sustaining procedures as those which "serve to secure only a precarious and burdensome prolongation of life."⁴¹ Mississippi has no statutory definition of "terminal" condition, but provides that directives should only be implemented when there is no possibility of meaningful recovery and "but for the use of life-sustaining mechanisms the declarant would immediately die."⁴² The Uniform Rights of the Terminally Ill Act⁴³ and states following it⁴⁴ require that death result in a relatively short time without life-maintaining procedures. The practical effect of living wills in these states which insist that death be close at hand is to prevent patients from being put unwillingly into intensive care or on life support systems during the last stages of the dying process, but not to prevent much else.

A number of other state statutes omit a temporal reference but say that an illness is terminal if life sustaining procedures only postpone death.⁴⁵ Wisconsin's language makes explicit the practical likelihood that this judgment will only be made when death is very near: "an incurable condition . . . that . . . would cause death imminently, so that the application of life sustaining procedures serves only to postpone the moment of death."⁴⁶ Finally, a few states say that an illness

statute, see Note, *The 'Terminal Condition' Condition in Virginia's Natural Death Act*, 73 VA. L. REV. 749 (1987).

⁴⁰ CONN. GEN. STAT. § 19a-572 (1987).

⁴¹ MD. HEALTH-GENERAL CODE ANN. § 5-601(e), (g) (Supp. 1986).

⁴² MISS. CODE ANN. § 41-41-113 (Supp. 1986).

⁴³ UNIFORM RIGHTS OF THE TERMINALLY ILL ACT § 1(9), 9b U.L.A. 612 (1987).

The commentary emphasizes that the reference is to condition rather than illness, and suggests that the phrase "relatively short time" means longer than "imminent." *Id.* § 1, at 613 (comment).

⁴⁴ HAW. REV. STAT. § 327D-2 (1986); IND. CODE ANN. § 16-8-11-9 (West Supp. 1987); MONT. CODE ANN. § 50-9-102(7) (1986); TENN. CODE ANN. § 32-11-103 (Supp. 1986).

⁴⁵ CAL. HEALTH & SAFETY CODE § 7187(y) (Deering Supp. 1987); COLO. REV. STAT. ANN. § 15-18-103(10) (Supp. 1986); D.C. CODE ANN. § 6-2421(6) (Supp. 1987); ILL. ANN. STAT. ch. 110½, para. 702(f) (Smith-Hurd 1987); LA. REV. STAT. ANN. § 1299.58.2(8) (West Supp. 1987); NEV. REV. STAT. § 449.590 (1986); ORE. REV. STAT. § 97.050(6) (1983); TEX. REV. CIV. STAT. ch. 71, art. 4590h, § 2(7) (Vernon Supp. 1987); UTAH CODE ANN. § 75-2-1103(7) (Supp. 1987); VT. STAT. ANN. tit. 18, § 5252(5) (Supp. 1986); WASH. REV. CODE ANN. § 70.122.020(7) (Supp. 1987); W. VA. CODE § 16-30-2(6) (1985).

⁴⁶ WIS. STAT. ANN. § 154.01(8) (West 1986).

is terminal if it will result in death despite the use of maintenance⁴⁷ or life sustaining treatment.⁴⁸ These states lack an explicit temporal reference, but cover only patients who will die whether or not life-support technology is employed. They thus exclude patients such as stroke victims who might be kept alive for relatively lengthy periods of time by respiration support or artificial feeding.

Living will statutes in California and Idaho particularly stress the terminal nature of the patient's condition. In both states, the patient cannot even make a living will until his terminal disease has been diagnosed.⁴⁹ California insists further that the patient have been notified at least fourteen days earlier of the diagnosis. For patients struck quickly, such as stroke or accident victims, the execution of a living will is a practical impossibility. California does, however, allow living will documents executed before a diagnosis of terminal illness to be treated as evidence of the patient's desires, along with reports from family and friends and other information known to the patient's physician.⁵⁰ The reason for insistence on a terminal diagnosis appears to be mistrust of desires formed before confronting the reality of death. However, terminal patients who remain competent—those who could make a living will after knowing of their conditions—remain able to revoke or change a living will made earlier. The result for the others is to deprive them of their only opportunity to memorialize their wishes directly.

When living wills are limited to terminal illness, directives are most likely to affect the deaths of people suffering from illnesses characterized by a progressive, relatively rapid downhill course. Some cancers are the primary examples. But directives will not change intervention decisions for patients with chronic or slowly deteriorating conditions, such as multiple sclerosis, muscular dystrophy, Alzheimer's disease, and amyotrophic lateral sclerosis in its earlier stages, or for patients with stable disabilities, such as brain damage from stroke or accident. But these groups of patients encompass many of those who might want to rely on a living will, and they will

⁴⁷ N.M. STAT. ANN. § 24-7-2(F) (1978).

⁴⁸ ARIZ. REV. STAT. ANN. § 36-3201(6) (Supp. 1986); DEL. CODE ANN. tit. 16, § 2501(c) (1983); GA. CODE ANN. § 31-32-2(10) (1985).

⁴⁹ CAL. HEALTH & SAFETY CODE § 7188 (Deering Supp. 1987); IDAHO CODE § 39-4504 (1977). In addition, the District of Columbia has a very odd provision about the relevance of terminal illness. It allows adult persons to make living wills at any time, but requires the physician to certify a terminal diagnosis and communicate it to the patient. The patient's living will does not become operative unless she is unable to comprehend the diagnosis. D.C. CODE ANN. § 6-2425(b) (Supp. 1987).

⁵⁰ CAL. HEALTH & SAFETY CODE § 7191(b) (Deering Supp. 1987).

not be able to do so. The only exception is New Mexico's extension of living wills to the irreversibly comatose.⁵¹

The ability to refuse treatment is further complicated for patients in Colorado and South Carolina, which have requirements that a patient be treated for a period after her living will is brought into play. South Carolina requires active treatment for six hours after the physician accepts a non-treatment declaration, presumably to ensure that the patient will not rally.⁵² Colorado requires life supports for forty-eight hours, to permit family members and the holder of any durable power of attorney to be given notice and the opportunity to challenge the validity of the living will.⁵³

B. *Revocation: The Fragility of Living Wills*

The general tendency of living will statutes is to make revocation extremely easy. The Uniform Act suggests the very simplest revocation provision. A living will may be revoked "at any time and in any manner" by its maker.⁵⁴ Comments say that this simplification is deliberate, to avoid any of the complexities that might be introduced by insistence on formalities. What the comments do not say is that this provision opens the door to unintended or erroneously reported revocations.⁵⁵ Multiple problems are involved here. The simplest is the risk of erroneous communication about whether a revocation has occurred, as when a well-meaning hospital team refuses to accede to a "do not resuscitate" order for a patient, under the false impression that the patient's living will has been revoked. A deeper problem is the issue of whether particular actions were meant to revoke a living will, as when a patient who can communicate very little says tearfully that she does not want to die. Perhaps the deepest philosophical issues, about autonomy and what respect for it requires, are raised by the patient whose present competence is questionable but who now apparently rejects a living will made earlier.

It seems likely that the less formality, the greater the chance of mistakes in reporting whether or not a revocation occurred and about whether particular actions were meant as a revocation. Several states

⁵¹ N.M. STAT. ANN. § 24-7-3.A (1978).

⁵² S.C. CODE ANN. § 44-77-30 (Law Co-op. Supp. 1986).

⁵³ COLO. REV. STAT. ANN. § 15-18-107 (Supp. 1986).

⁵⁴ UNIFORM RIGHTS OF THE TERMINALLY ILL ACT § 4(a), 9b U.L.A. 616 (1987). Montana is among the states following the Uniform Act. MONT. CODE ANN. § 50-9-104 (1986).

⁵⁵ For a discussion of the ethical issues posed by second hand reports of patient desires, see *Case Study: A Cardiac Arrest and a Second Hand Report*, 16 HASTINGS CENTER REP. 15 (Dec. 1986).

do insist on more formality than the Uniform Act. Some provisions focus on the reliability of the communicative process. A number of states provide that revocations do not become effective until they are communicated to the attending physician by the patient or someone acting at his direction.⁵⁶ A few states make revocations effective when the physician receives either a written revocation from the patient or a written confirmation from witnesses to an oral revocation.⁵⁷ Tennessee requires that oral revocations be made in the presence of the patient's attending physician.⁵⁸ Many states, however, have no safeguards at all about communication of a revocation.

Other states insist on further formalities to identify the event of revocation. Typical provisions are that a living will may be revoked by being obliterated, torn, or otherwise deliberately damaged; by written revocation; or by oral revocation. A few states go even beyond oral revocation to allow non-verbal revocation.⁵⁹ Maryland does not allow oral revocations until after the declarant knows of his terminal condition.⁶⁰ A number of states allow an oral revocation without insisting that the revocation be witnessed.⁶¹ Among the states requiring oral revocations to be witnessed, some require only one witness,⁶² others two.⁶³ Vermont insists on two witnesses, one of whom must not be a spouse or a relative, presumably to avoid undue familial

⁵⁶ See, e.g., ARIZ. REV. STAT. ANN. § 36-3203(b) (Supp. 1986); CAL. HEALTH & SAFETY CODE § 7189(a)(2), (3) (Deering Supp. 1987); D.C. CODE ANN. § 6-2424(a)(3) (Supp. 1987); GA. CODE ANN. § 31-32-5(a)(2), (3) (1985); NEV. REV. STAT. § 449.620.1 (1986); N.C. GEN. STAT. § 90-321(e) (1985); S.C. CODE ANN. § 44-77-80 (Law Co-op. Supp. 1986); TEX. REV. CIV. STAT. ANN. ch. 71, art. 4590h, § 4(a)(2), (3) (West Supp. 1987); WASH. REV. CODE ANN. § 70.122.040(b), (c) (Supp. 1987); W. VA. CODE § 16-30-4(a)(2), (3) (1985); WIS. STAT. ANN. § 154.05(c) (West 1986).

⁵⁷ E.g., ALA. CODE § 22-8A-5(a) (1975); HAW. REV. STAT. 327D-12 (1986); ILL. ANN. STAT. ch. 110½, para. 705 5(a)(3) (1987); UTAH CODE ANN. § 75-2-1111(2) (Supp. 1987).

⁵⁸ TENN. CODE ANN. § 32-11-106(2) (Supp. 1986).

⁵⁹ GA. CODE ANN. § 31-32-5(a)(3) (1985) (allowing verbal or non-verbal expressions of intent to revoke); LA. REV. STAT. ANN. § 40:1299.58.4(3)(a) (West Supp. 1987) (allowing oral or non-verbal revocation); N.C. GEN. STAT. § 90-321(e) (1985) (allowing revocation by any manner of communication).

⁶⁰ MD. HEALTH-GENERAL CODE ANN. § 5-603(2) (Supp. 1986). The most likely explanation for the policy is that speed in revocation is not an issue before a patient is diagnosed as terminally ill.

⁶¹ See, e.g., ARIZ. REV. STAT. ANN. § 36-3203(a)(3) (Supp. 1986); FLA. STAT. ANN. § 765.06(3) (West 1986); IND. CODE ANN. § 16-8-11-13(a)(3) (West Supp. 1987); NEV. REV. STAT. § 449.620.1 (1986); S.C. CODE ANN. § 44-77-80 (Law Co-op. Supp. 1986); TEX. REV. CIV. STAT. ANN. ch. 71, art. 4590h, § 4(3) (Vernon Supp. 1987); VA. CODE ANN. § 54-325.8:5 (Supp. 1987); WASH. REV. CODE ANN. § 70.122.040(c) (Supp. 1987); WIS. STAT. ANN. § 154.05(c) (West 1986).

⁶² E.g., UTAH CODE ANN. § 75-2-1111(1)(c) (Supp. 1987).

⁶³ E.g., DEL. CODE ANN. tit. 16, § 2504(a)(2) (1983); N.H. REV. STAT. ANN. § 137-H:7(c) (Supp. 1986); VT. STAT. ANN. tit. 18, § 5257 (Supp. 1986).

pressure.⁶⁴ States also divide on whether a signed and dated confirmation of the revocation by the witnesses is necessary.⁶⁵ Mississippi provides the most highly formal revocation procedure. In Mississippi, revocations must be written, signed witnessed, and, like living wills themselves, filed with the state bureau of vital statistics. Only a patient who cannot execute a written revocation may perform an oral one.⁶⁶ These formalities decrease the risk that casual comments will be taken as a revocation. On the other hand, they may make it more difficult for patients with limited communicative or physical abilities to effect desired revocations.

The Uniform Act also stipulates that revocations may occur regardless of the physical or mental condition of the living will's maker.⁶⁷ This provision is echoed in the living will legislation of nearly half of the states.⁶⁸ The remainder simply provide that revocations may occur at any time. Thus states are unanimous in insisting that revocations are valid, no matter what the mental state of the declarant. Current expressed choices prevail over earlier documentation, no matter how ill-considered or hasty they are, how well they cohere with the remainder of a life, or how questionable the competence of the person expressing them.

Such fragility is desirable, if we want to ensure that no one is taken to have refused treatment who really desires to have it. Fragility is problematic, if patients are treated when they would prefer not to be. Fragility protects life and it protects the autonomy of those patients whose choices are accurately reflected in effective revocations. It risks the autonomy and privacy of patients who are taken to have revoked when they did not mean to have done so. These risks are especially high when communications of incompetent patients are not well understood. The choice is between policies that risk life, and policies

⁶⁴ VT. STAT. ANN. tit. 18, § 5257 (Supp. 1986).

⁶⁵ Compare ALA. CODE § 22-8A-5(a) (1975); D.C. CODE ANN. § 6-2424(a)(2) (Supp. 1987); OR. REV. STAT. § 97-055(5)(b) (1983); UTAH CODE ANN. § 75-2-1111(c) (Supp. 1987); W.VA. CODE § 16-30-4 (1985), which require written confirmation by witness, with HAW. REV. STAT. § 327D-12 (1986); ILL. STAT. ch. 110½, para. 705(5)(a) (Smith-Hurd 1987); N.M. STAT. ANN. § 24-7-6 (1978), which does not require confirmation.

⁶⁶ MISS. CODE ANN. § 41-41-109(1), (3) (Supp. 1986).

⁶⁷ UNIFORM REGULATIONS OF THE TERMINALLY ILL ACT § 4(a), 9b U.L.A. 616 (1987).

⁶⁸ ARIZ. REV. STAT. ANN. § 36-3203 (Supp. 1986); CAL. HEALTH & SAFETY CODE § 7189(a) (Deering Supp. 1987); DEL. CODE ANN. tit. 16, § 2504(a) (1983); D.C. CODE ANN. § 6-2424 (Supp. 1987); GA. CODE ANN. § 31-32(5)(a) (1985); HAW. REV. STAT. § 327D-7 (1986); LA. REV. STAT. ANN. § 40:1299.58.4 (West Supp. 1987); MONT. CODE ANN. § 50-9-104 (1986); N.C. GEN. STAT. § 90-321(e) (1985); S.C. CODE ANN. § 44-77-80 (Law Co-op. Supp. 1986); TENN. CODE ANN. § 32-11-106 (Supp. 1986); TEX. REV. CIV. STAT. ANN. ch. 71, art. 4590h, § 4(a) (Vernon Supp. 1987); WASH. REV. CODE ANN. § 70.122.040 (Supp. 1987); W.VA. CODE § 16-30-4 (1985).

that risk the right to privacy. Certainly, it is desirable to try to reduce the conflict by revocation procedures that guard against error, requiring witnesses and confirmation for example. But to the extent that the conflicts are uneliminable, and life is viewed as more important than privacy, it is reasonable to err on the side of fragility.

Living wills also clearly take second place to a patient's current desires. Some states provide explicitly that declarants' desires at all times override their living wills.⁶⁹ Delaware combines a stipulation that the desires of a competent patient supersede a living will with the provision that, competent or incompetent, a patient may revoke a living will.⁷⁰ Several states require the attending physician to ascertain whether a living will remains in accord with the patient's current desires before acting under the directive.⁷¹ Other states accord only evidentiary status even to fully operative living wills.⁷² Desires may be ill-considered and fit poorly with someone's overall approach to life, however. To the extent that desires do not reflect longstanding choices, letting them supersede living wills is harder to justify on grounds of autonomy than letting living wills be revoked easily.

C. *The Patient and Decision-Making Without a Living Will*

Ironically, the limited scope and fragility of living wills persist despite recognition of the underlying right to refuse medical treatment. Indeed, one may be more able to turn down care without a living will, if one is vocal enough about one's desires, than to do so under an advance directive. The administration of medical care without consent is a battery, and the failure to use reasonable care to assure informed consent is malpractice. Competent patients have the right to refuse care, based on the constitutional right to privacy.⁷³ This right has been held to override such state interests as preserving life, preventing suicide, protecting the medical profession, and protecting

⁶⁹ E.g., ARIZ. REV. STAT. ANN. § 36-3205A (Supp. 1986); D.C. CODE ANN. § 6-2426(a) (Supp. 1987); HAW. REV. STAT. § 327D-7 (1986); ILL. STAT. ANN. ch. 110½, para. 707 (Smith-Hurd 1987); W. VA. CODE § 16-30-6(a) (1985); WIS. STAT. ANN. § 154.07(2) (West 1986); UTAH CODE ANN. § 75-2-1108 (Supp. 1987).

⁷⁰ DEL. CODE ANN. tit. 16, § 2504(a) (1983).

⁷¹ TEX. REV. CIV. STAT. ANN. ch. 71, art. 4590h, § 7(a) (Vernon Supp. 1987); WASH. REV. CODE ANN. § 70.122.060(1) (Supp. 1987).

⁷² IND. CODE ANN. § 16-8-11-11(f) (West Supp. 1987) (declaration presumptive evidence); NEV. REV. STAT. § 449.640.1 (1986) (physician must give weight to living will as evidence of desires, but may consider other factors as well).

⁷³ See, e.g., *In re Farrell*, 529 A.2d 404 (N.J. 1987); *Schloendorff v. Society of New York Hosp.*, 211 N.Y. 125, 105 N.E. 92 (1914); *Schultz, From Informed Consent to Patient Choice: A New Protected Interest*, 95 YALE L.J. 219 (1985).

innocent third parties such as children.⁷⁴

In recent years, courts have increasingly struggled with whether the constitutional right to privacy also extends to the right of no-longer-competent patients to have care refused on their behalf. Two standards have emerged: substituted judgment, or what the patient would himself have chosen; and best interests, or what maximizes enjoyment and minimizes pain for the patient.

In perhaps the first and most famous of the contemporary right to refuse treatment cases, *In re Quinlan*,⁷⁵ the New Jersey Supreme Court held that evidence of Karen Ann Quinlan's own desires was too scanty to permit treatment to be refused as her exercise of her own right to privacy. They appointed her father as her guardian, however, to exercise his best judgment on her behalf. Since *Quinlan*, New Jersey case law has gradually concluded that incompetent patients have the right to refuse treatment and developed a complex set of tests to enable them to exercise that right.

In cases involving incompetent patients, New Jersey looks both to the patient's prognosis and to the available evidence reflecting what she would have chosen. In *In re Conroy*,⁷⁶ the New Jersey Supreme Court faced the question of whether to discontinue artificial feeding for a severely impaired, but not comatose elderly woman confined to a nursing home. The court developed a three-level test for such cases, coordinating both substituted judgment and New Jersey's version of the best interests test, in the effort to accommodate both the patient's right to choose and the patient's right to life. If there is clear evidence that an incompetent patient would have wanted to refuse treatment, these subjective preferences prevail. If there is some trustworthy evidence that the patient would have refused treatment, a "limited objective" test is applied: treatment is refused if the burdens of the patient's life with the treatment "markedly" outweigh its benefits. If there is no evidence of the patient's desires, treatment is not withheld unless the burdens of continued existence "clearly and markedly" outweigh benefits and the patient is suffering so much pain that to continue life would be "inhumane."⁷⁷ New Jersey thus

⁷⁴ *In re Farrell*, 529 A.2d 404. With respect to the interests of children, the New Jersey court noted that Mrs. Farrell had no prospect for recovery from amyotrophic lateral sclerosis, and her husband was able to care for their two sons.

⁷⁵ 70 N.J. 10, 355 A.2d 647, cert. denied sub nom., *Garger v. New Jersey*, 429 U.S. 922 (1976).

⁷⁶ 98 N.J. 321, 486 A.2d 1209 (1985); see also *In re Clark*, 210 N.J. 548, 510 A.2d 136 (Sup. Ct. Ch. Div. 1986).

⁷⁷ *In re Peter*, 529 A.2d 419 (N.J. 1987); *In re Farrell*, 529 A.2d 404 (N.J. 1987); *In re Jobes*, 529 A.2d 434 (N.J. 1987).

applies substituted judgment when the patient's desires are apparent; and when the patient's desires are not evident, the state insists that continued existence be ever more painful to justify termination of treatment.

It is difficult, however, to apply these tests to the situation of someone in a persistent vegetative state. Since death is not likely soon, and since pain is not intractable, either the limited-objective or the objective test would suggest continuation of treatment. In two very recent cases, the New Jersey Supreme Court has held that these tests are inapplicable to patients in a persistent vegetative state. When there is clear evidence of what a vegetative patient would have wanted, New Jersey continues to apply the subjective test.⁷⁸ When there is no clear evidence, however, New Jersey allows either the patient's family or guardian to decide for the patient, with appropriate procedural safeguards to ensure that there is no reasonable possibility of return to cognitive life.⁷⁹

Several other states have also adopted versions of the substituted judgment and best interest tests. California has case law permitting a competent person to decline treatment even though his illnesses are not likely to cause imminent death⁸⁰ and allowing treatment to be withdrawn from an incompetent, terminally ill patient.⁸¹ Massachusetts has permitted artificial feeding to be discontinued on a substituted judgment standard for a patient in a persistent vegetative state.⁸²

A Florida case, however, is perhaps the most telling of all about the limited impact of living will legislation. In *Corbett v. D'Alessandro*,⁸³ the Second Appellate District Court upheld the discontinuation of artificial feeding for a terminally ill, vegetative patient, with the concurrence of the patient's physician and husband that this was in her best interests. Mrs. Corbett did not have a living will, and the Florida living will statute specifically precludes the discontinuation of nutrition under an advance directive. Nevertheless, the court held that the patient's constitutional rights to refuse nutrition and hydration were not curtailed by the living will legislation.⁸⁴

⁷⁸ *In re Peter*, 529 A.2d 419 (N.J. 1987).

⁷⁹ *Id.*; *In re Jobes*, 529 A.2d 434 (N.J. 1987).

⁸⁰ *Bartling v. Superior Court*, 163 Cal. App. 3d 186, 209 Cal. Rptr. 220 (Cal. Dist. Ct. App. 1984).

⁸¹ *Barber v. Superior Court*, 147 Cal. App. 3d 1006, 195 Cal. Rptr. 484 (Cal. Dist. Ct. App. 1983).

⁸² *Brophy v. New England Sinai Hosp., Inc.*, 398 Mass. 417, 497 N.E.2d 626 (1986).

⁸³ 487 So.2d 368 (Fla. Dist. Ct. App. 1986).

⁸⁴ *Id.* at 372.

D. *Third Parties: The Durable Power of Attorney and the Patient's Relatives*

It is in the role of third parties that living wills contrast most sharply with ordinary wills. With the exception of trusts created by the testator, surrogacy is not involved in decisionmaking about property transfers after death, yet it is common in the living will context. Provisions about surrogacy may be defended as extensions of the patient's autonomy, allowing others to carry on as the patient would have wished, when the patient can no longer act for himself. The interests of third parties, however, may also be involved in surrogate decisionmaking. Interests in another's dying range from convenience, to financial concerns, to grief at the suffering of a loved one, to intense involvement in the last moments of a lifelong partner. These interests are of varying moral weight, but they cannot all be dismissed as morally unworthy.

Living will statutes appear in the main to treat surrogacy as an extension of patient autonomy. Provisions vary, however, and it is not always clear that autonomy is the interest being protected. Connecticut will not permit termination of life supports under a patient's living will, without informed consent from next of kin or legal guardian.⁸⁵ Colorado insists on active treatment for forty-eight hours, in order to allow the holder of a durable power of attorney or members of the patient's family to challenge the validity of a living will.⁸⁶ Several states provide specifically for consultation with relatives when the validity of a living will is in doubt.⁸⁷ On the other side, Utah allows a living will to be revoked by the person who signed the declaration on behalf of another, based on changed circumstances or a change of mind.⁸⁸ Finally, a number of states permit family members to refuse treatment on behalf of a patient who lacks a living will.⁸⁹

⁸⁵ CONN. GEN. STAT. § 19A-571 (1987).

⁸⁶ COLO. REV. STAT. ANN. § 15-18-107 (Supp. 1986).

⁸⁷ IND. CODE ANN. § 16-8-11-14(G) (West Supp. 1987).

⁸⁸ UTAH CODE ANN. § 75-2-1111(a) (Supp. 1987).

⁸⁹ ARK. STAT. ANN. § 82-3803 (1985); FLA. STAT. ANN. § 765.07 (West 1986) (life-prolonging treatment may be withheld from incompetent patient without declaration if written agreement between attending physician and, in priority, guardian, holder of a durable power of attorney, spouse, child, parents, other nearest kin); LA. REV. STAT. ANN. § 40:1299.58.5(2) (West Supp. 1987); N.M. STAT. ANN. § 24-7-8.1.A (1978) (treatment may be refused on substituted judgment standard when patient lacks a living will and all family members agree patient would choose to forgo treatment); N.C. GEN. STAT. § 90-322(b) (1985) (treatment of terminally ill may be discontinued by concurrence of spouse, guardian, or a majority of first degree relatives); OR. REV. STAT. § 97.083 (1983) (spouse, guardian, parents, majority of adult children, physician in order of priority may discontinue treatment for a terminally ill, comatose patient without a living will); TEX. REV. CIV. STAT. ANN. ch. 71, art. 4590h, § 4c (Vernon Supp. 1987) (guardian, or

Only Vermont suggests explicitly that others have a moral duty to honor a patient's wishes as expressed in an advance directive, in recommended living will language: "Insofar as [my desires expressed here] are not legally enforceable, I hope that those to whom this will is addressed will regard themselves as morally bound by these provisions."⁹⁰

States with living will statutes frequently have durable power of attorney statutes as well. Durable power of attorney statutes allow individuals to designate someone else to make health care decisions for them, should they become incompetent. Durable power statutes have the advantage of allowing the creation of decision-making mechanisms that function whenever incompetence occurs. In states like California, that do not fully recognize living wills executed before a terminal diagnosis, creation of a durable power may be the only way for a non-terminal patient to continue to direct her care, albeit through an intermediary. A durable power is, however, a power exercised by someone else, and can only be regarded as a continued expression of autonomy to the extent that the holder of the power acts as the principal would have wanted him to do.

In states with both living will and durable power of attorney statutes, groups such as American Association of Retired Persons regularly advise people to take advantage of both mechanisms. They point out, quite rightly, that the mechanisms cover different situations. But this introduces the possibility of conflict. The holder of the durable power may want to go beyond the patient's living will. For example, to turn down nutrition when either the living will fails to mention it or state law prohibits its inclusion. Or the holder of the durable power may think the maker of the living will countermanded too many types of treatment. Here, too, food and nutrition are likely examples.

Most state statutes simply ignore the possibility of conflict under the two types of directives. The exception is Utah, which provides that decisions of the holder of the durable power trump directions in the living will.⁹¹ Utah's allows the holder of the durable power to re-

attending physician and if available at least two of spouse, majority of adult children, parents, other nearest living relative may refuse treatment, guided by any known desires of patient); VA. CODE ANN. § 54-325.8:6 (Supp. 1987) (for comatose, terminal patient without directive, treatment may be refused by guardian, holder of durable power or, if available, two of spouse, adult child, parents, nearest living relative); UTAH CODE ANN. § 75-2-1107 (Supp. 1987) (treatment may be discontinued with written consent of two physicians and, in priority, guardian, spouse, parents, next of kin, or legal guardian to be appointed for this purpose).

⁹⁰ VT. STAT. ANN. tit. 18, § 5253 (Supp. 1986).

⁹¹ UTAH. CODE ANN. § 75-2-1102(2) (Supp. 1987).

spond flexibly to changing circumstances but for protection of autonomy depends heavily on her ability to follow what the patient would have wanted. Arizona specifies that provisions in a living will control decisions of any guardian later appointed for its maker.⁹² Arizona's approach has the advantages and disadvantages of perpetuating the patient's past voice over a guardian.

IV. POLICY ARGUMENTS FOR FORMALITY AND FRAGILITY

It is the requirement of formalities that give real wills the performative structure so lacking for living wills. Without the formalities of execution or revocation, a potential testator's desires do not alter the legal disposition of property. A patient's desires, by contrast, may be invoked to terminate treatment without the formality of a living will and may overwhelm even a formally executed living will. Patient autonomy, and even decisions made by third parties, continue to be recognized despite the existence of living will statutes.

Commentators on the law of real wills begin with the liberal premise that an owner has the power to dispose of his property.⁹³ The formalities of the law of wills in general further the owner's efforts to realize his intentions, in several ways. Because they make the execution of a will a moment of ceremony, they help ensure that a will or a revocation reflects a final decision of its maker—that he has made up his mind, rather than merely commenting about what he might do. Because they identify a particular document as memorializing the testator's intentions, they are thought to increase the reliability of evidence presented to a probate court. Finally, although more problematic, they may help protect the testator against undue pressure in disposing of his property.⁹⁴

Commentators on the law of real wills also point out, however, that insistence on formalities may frustrate the testator's actual plans. Stock examples are the person who dies intestate because what he believed was a valid will was improperly signed or witnessed, and the person who does not understand the legal effect of a testamentary

⁹² ARIZ. REV. STAT. ANN. § 36-3206(1) (Supp. 1986).

⁹³ E.g., Gulliver & Tilson, *Classification of Gratuitous Transfers*, 51 YALE L.J. 1, 2 (1941); Langbein, *Substantial Compliance with the Wills Act*, 88 HARV. L. REV. 489, 491 (1975) ("The first principle of the law of wills is freedom of testation. Although the state limits the power of testation in various ways, within the province that remains to the testamentary power, virtually the entire law of wills derives from the premise that an owner is entitled to dispose of his property as he pleases in death as in life.").

⁹⁴ Gulliver and Tilson argue that formalities do little to protect and that there is no reason to believe contemporary testators, typically in the prime of life, any more vulnerable than other gratuitous transferors. Gulliver & Tilson, *supra* note 93, at 9.

provision.

The formalities for real wills, however, serve functions other than realizing the actual desires of the testator. Judicial efficiency, the avoidance of frequent and protracted litigation, and certainty in the disposition of property are three important functions. The formalities force wills into standardized structures, thus simplifying the task of probate.⁹⁵ They avoid litigation over whether the will reflects what its maker really wanted, either at the time he made the will or later on.⁹⁶ Interpreting wills as free-standing documents, rather than in light of what is known about the testator and his desires, furthers reliability about the disposition of property.⁹⁷

Recent criticisms of the law of real wills have been directed at its formalism. Langbein, for example, defends a doctrine of "substantial compliance," under which proponents of a formally defective document could prove that it, nevertheless, evidences final testamentary intent.⁹⁸ His position, however, does not ignore the policy concerns of efficiency and certainty. Langbein contends that substantial compliance would not decrease the channeling function of wills—their ability to impress on the testator the recognition that she is indeed making a will—because it would be confined to situations in which the testator really meant to make a will, and thus would not confuse other forms of voluntary transfers with wills. Against the argument that "substantial compliance" foster litigation, Langbein hypothesizes that the doctrine is likely to exchange litigation in cases in which formalism yields frank injustice for litigation over whether the purported will fulfills the purposes of the probate statutes.⁹⁹

Autonomy, in the sense of the freedom to choose what will happen to one's person, surely is the fundamental premise of the law of living wills as well. Finality and the reliability of evidence are crucial, too; one of the major advantages of the living will mechanism is that it provides a clear statement of its maker's wishes about medical treatment. Indeed, living will statutes typically insist on highly formalized procedures for making a living will, including signature in the pres-

⁹⁵ Langbein calls this the "channeling function." Langbein, *supra* note 93, at 494.

⁹⁶ *Id.* at 501.

⁹⁷ Friedman, *Law, Rules, and the Interpretation of Written Documents*, 59 NW. U. L. REV. 751, 765 (1964). Friedman, however, suggests that as other features of the structure of the real estate market, such as title insurance, take over this function, traditional rules about interpretation of wills have softened to admit evidence extrinsic to the document in some cases. *Id.* at 770.

⁹⁸ Langbein, *supra* note 93, at 514. For a similar discussion about Australian law, see Lang, *Formality v. Intention—Wills in an Australian Supermarket*, 15 MELB. U. L. REV. 82 (1985).

⁹⁹ Langbein, *supra* note 93, at 525.

ence of two witnesses. This is the requirement suggested in the Uniform Rights of the Terminally Ill Act, and it parallels the provision for making real wills in the Uniform Probate Code.¹⁰⁰ This requirement clearly helps to ensure that both documents represent final judgments and are authentic.

Protecting patients from undue pressure, however, remains of more concern for living wills than for real wills. Drafters of the Uniform Probate Code were apparently convinced that further formal requirements, such as the traditional rule that witnesses not take under the will, were more likely to frustrate genuine efforts to make wills than to protect testators from manipulation.¹⁰¹ Under the Uniform Probate Code, therefore, a legatee may witness the execution of the will. Not all states were equally sanguine; Utah, for example, limits interested witnesses to the lesser of the amount provided in the will or the amount they would take had the testator died intestate.¹⁰² Many state living will statutes, however, insist on further formalities.¹⁰³ The most common is a prohibition of witnesses who are interested by reason of being relatives, heirs, or financially responsible for the declarant's medical care.¹⁰⁴ A number of states also prohibit the declarant's attending physician or employees of a health care facility in which he is a patient from witnessing his living will.¹⁰⁵ Several states require an ombudsman to be present when a living will is made by an elderly resident of a nursing homes.¹⁰⁶ Perhaps the insistence on disinterested witnesses for real wills can be regarded as an artifact of the days when wills were made on death beds rather than in attorneys'

¹⁰⁰ Compare UNIF. RIGHTS OF THE TERMINALLY ILL ACT § 2(a), 9b U.L.A. 614 (1987) with UNIFORM PROBATE CODE § 2-502 (1982).

¹⁰¹ UNIFORM PROBATE CODE § 2-502 & comment (1982); Langbein, *supra* note 93, at 496.

¹⁰² UTAH CODE ANN. § 75-2-505 (Supp. 1987).

¹⁰³ Perhaps the least formal is Virginia, which simply requires two witnesses and permits oral declarations. VA. CODE ANN. § 54-325.8:3 (Supp. 1987).

¹⁰⁴ ALA. CODE § 22-8A-4(a) (1975); ARIZ. REV. STAT. ANN. § 36-3202 (Supp. 1986); ILL. ANN. STAT. ch. 110½, para. 703(e) (Smith-Hurd 1987); IND. CODE ANN. § 16-8-11-11(c) (Supp. 1987).

¹⁰⁵ CAL. HEALTH & SAFETY CODE § 7188 (Deering Supp. 1987); DEL. CODE ANN. tit. 16, § 2503(b) (1983); D.C. CODE ANN. § 6-2422(a)(4)(e) (Supp. 1987); GA. CODE ANN. § 31-32-3(a)(3) (1987); IDAHO CODE § 39-4504 (1977); MD. HEALTH-GENERAL CODE ANN. § 5-602(a) (Supp. 1986); MISS. CODE ANN. § 41-41-107(1) (Supp. 1986); NEV. REV. STAT. § 449.600 (1986); N.H. REV. STAT. ANN. § 137-H:4 (Supp. 1986); N.C. GEN. STAT. § 90-321(c)(3) (1985); OR. REV. STAT. § 97.055(2) (1983); S.C. CODE ANN. § 44-77-40 (Law. Co-op. Supp. 1986); TENN. CODE ANN. § 32-11-104 (Supp. 1986); TEX. REV. CIV. STAT. ANN. ch. 71, art. 4590h, § 3(a) (Vernon Supp. 1987); WASH. REV. CODE ANN. § 70-122.030(1) (Supp. 1987); W. VA. CODE § 16-30-3(b) (1985); WIS. STAT. ANN. § 154.03(1) (West 1986) (permits employees of health care facility to witness if they are not directly involved in the patient's care); VT. STAT. ANN. tit. 18, § 5254 (Supp. 1986).

¹⁰⁶ *E.g.*, DEL. CODE ANN. tit. 16, § 2506(c) (1983); D.C. CODE ANN. § 6-2423 (Supp. 1987); OR. REV. STAT. § 97.055(3) (1983); S.C. CODE ANN. § 44-77-60 (Law Co-op. Supp. 1986).

offices.¹⁰⁷ Drafters of living will legislation, however, clearly remain convinced of the importance of protecting the vulnerable from pressure to terminate increasingly costly care.

Once a living will has been made, however, concern for the formalities wanes. Instead, the primary policy consideration is avoiding termination of care for a patient who now chooses to have continued care. The fragility of living wills is the result, and to some extent it can be justified. Particularly for frail patients, whose strength and lucidity fluctuate, making revocation easy increases the likelihood that patients will be able to effectuate genuine revocation decisions. But the fragility of living wills outstrips the justification for easy revocation. If the formalities of living wills serve a ceremonial function akin to that of real wills—reminding their makers that a decision is being made—revocation should similarly be an identified event. To let apparent patient desires supersede a valid living will risks letting ill-formed and short-lived desires overrule a longstanding choice. Moreover, autonomy is ignored when living wills can be countermanded by family members or other third parties, with the possible exception of a holder of a durable power of attorney who at least has been chosen by the maker of the living will.

Finally, as with real wills, an advantage of living will legislation is that uncertainty and litigation over non-treatment decisions may be avoided when patients execute advance directives. To the extent that current living will legislation is limited to the terminally ill, and to certain forms of treatment, it achieves these goals only imperfectly. It is perhaps not because they have aging populations that New Jersey, Massachusetts and New York, and California have experienced some of the most extensive litigation over non-treatment decisions. Among those states, only California has a living will statute, and it is limited to documents executed after the onset of a terminal condition.

Judicial efficiency and avoiding painful controversy might not be enough to justify extending the scope of living wills. But autonomy is crucial here too. Patients cannot now make directives that cover their care in non-terminal conditions, or that extend to certain kinds of care. The most important argument against expanding the scope of living wills is the protection of life. However, incompetent patients have been held to have constitutional privacy rights to refuse treatment which outstrip the scope of current living wills, despite limits derived from the state interest in protecting life. A reasonable approach, therefore, would be to expand the scope of living wills to situ-

¹⁰⁷ Gulliver & Tilson, *supra* note 93, at 10.

ations in which the constitutional right to refuse treatment is clear. This would include allowing non-treatment directives to cover conditions such as irreversible coma or a persistent vegetative state in which there are no real prospects for return to cognitive life. It would certainly warrant expanding definitions of terminal illness beyond the very last stages of an otherwise hopeless disease process. It would also justify extending the types of treatment that may be refused to include additional forms of care that are life-prolonging without being curative or ameliorative. This approach furthers both autonomy and reliability of evidence about patient choices, without undermining the state's interest in protecting the lives of those who have become incompetent.

V. CONCLUSION

Living wills are limited and evanescent, in order to preserve life. Their evanescence can be partially justified, but their limits can not be defended as easily.

Reconsidering the case of the woman with amyotrophic lateral sclerosis illustrates these claims. If she lives in a state with living will legislation, she will be able to draft a document in which she declines respirator support. In many states, however, she will not be able to use her living will to turn down nutrition or many other forms of care, and thus make a reliable statement of her final views on these matters. Nor will she be able to direct her care unless she is terminally ill or, in New Mexico, comatose. In some states, this will mean that she will not be able to speak through her living will until her disease has reached the most advanced stages.

The force of her living will, moreover, will disintegrate easily, even for those matters it addresses. Revocations do not require formalities, and therefore, may be communicated unreliably. In a context in which communication is problematic, the least suggestion of doubts about what she now wants may suffice to supersede her living will. She may not even know that this is what has happened. Others—her guardian, her relatives, or the holder of her durable power of attorney—may countermand what she has said in her living will.

If her autonomy is paramount, her present considered choice should replace earlier memorialized decisions. Fleeting or ill-considered judgments, however, less clearly further autonomy—much less imperfectly communicated desires, someone else's impression of what she might be thinking, or, even worse, someone else's impression of what she should be thinking. It is even a further threat to her autonomy to let someone else's judgment supersede her living will, unless,

as in Utah, she specifically assigned that person the power to make health care decisions on her behalf should she become incompetent. Of course, there will be patients without living wills; third-parties must decide about their treatment, and it is desirable to have them draw as much as possible on what is known of her desires. But if she made a living will, it was in hopes that it would avoid the need for such surrogacy, yet in some states it unfortunately may not.

Even though her competence is questionable, she may revoke her living will at any time. This is desirable if treatment decisions are to reflect current choices. Nevertheless, the moral problem of Ulysses and the Sirens should at least remind us to be as careful in how we identify and verify revocations of living wills, as we are in their making.